AMCHP Annual Conference, 2010

Moving Ahead Together:

Celebrating the Legacy, Shaping the Future of Maternal and Child Health

Prevention and Early Intervention:

Developing a System to Improve Perinatal and Parental Mental Health Outcomes

March 6-10, 2010

LIBRADA ESTRADA: Good afternoon everyone. My name is Librada Estrada and I'm associate director of workforce development and family involvement at AMCHP. I'd like to welcome you to this afternoon's session. This session is entitled Prevention and Early Intervention: Developing a System to Improve Perinatal and Parental Mental Health Outcomes. It is session ID G7, which is a workshop session. This session is eligible for continuing education and I'm sure you've heard this several times already, there is a link to the CDC training and continuing education online system. It is posted on the AMCHP website and in order to receive continuing education credit you must complete the online form by April the 12th, so be sure to keep track of all of these sessions.

Also, we will be handing out or I will be handing out and individual AMCHP session evaluation before the end. Make sure you return that to me and you will be receiving an overall evaluation form at the end of the conference.

And now I would like to introduce or actually have our first speaker. Doctor.

ARDIS OLSON: Welcome. Thank you for being here end of the afternoon on a Sunny day when people would like to be other places. We have a group of four speaker today that will take you from the range of national reports and task force, first about parent depression, then about preventing mental health problems in children and adolescents, through to more specific program that will be LA County wide, how they implement perinatal mental health programs and a specific program in Chicago that will show how they built a port program for physicians managing maternal depression. We're very excited to have you here. It helps us a little bit to get a sense of who is in the audience because we're talking to people. We have no idea how many people work in a public health… Give us an example of your background. Anybody want to volunteer?

AUDIENCE: State Health Department.

ARDIS OLSON: State Health Department. Okay, what role?

AUDIENCE: Title V ****.

DR. ARDIS OLSON: Title V. Okay, someone else?

AUDIENCE: College of Public Health.

DR. ARDIS OLSON: College of Public Health, okay. Yep.

AUDIENCE: The Early Childhood Development Assistance Program.

ARDIS OLSON: For your state?

AUDIENCE: Yes.

ARDIS OLSON: Okay. Any other perspectives we're missing here?

AUDIENCE: ****

ARDIS OLSON: Great, okay. Anybody else? Okay, so we have a lot of people who are responsible for making programs happen and we're really excited then to share these opportunities with you. My name is Ardis Olson. I'm from Dartmouth Medical School. I'm a pediatrician who has long been concerned about how these issues impact parents and I was fortunate enough to get to be on the Institute of Medicine Taskforce on Depression in Parents looking at opportunities to improve identification, treatment and prevention, so I'm first going to tell you about that committee and their findings. We have a peer for both of the IOM committees, their summary reports, their briefs and how to access the whole report online, so you have access to that. We took these from Mac to PC, so these interesting little things on the bottom are because of translation. I do not know what I'm going to get here. So the committee had the important task to review the relevant literature on the identification, prevention and treatment of parental depression, its interaction with parenting practices and what are its affects on children and family

and although there is a lot of literature out there this is one of the few places you're going to find the link from A to B to C laid out for you and it's a tremendous resource from that standpoint. We have an amazing committee with people who are experts from all over the country representing public health, pharmacy, primary care, psychiatry, family services, people who have done major research and policy development in the field.

A couple just key things to talk about, I think this is speaking to the choir, so much of this you'll know, but let's just emphasize that it's very prevalent and impairing and affects 20% of adults in their lifetime and 40 to 70% never get treated. Many of these adults are parents and here is where the gap lies in the literature that is being presented about depression nationwide. They have similar rates, similar disparities as other adults do, leading to about 7½ million parents affected every year and at least 15.6 million children living with a parent who has had major depression in the last year. Those are phenomenal numbers in terms of impact on children. We ran some new data and found that in the past year 10% of parents with a child under 18 in their home had depression in the last year, phenomenal numbers here. So one of the key take home messages is that for parents depression can interfere with parenting quality and put children at risk for poor physical, emotional and developmental help at all ages and a lot of what will be presented here are focused on the perinatal and the newborn period of life, but it's key for people in public programs to recognize that parental depression rates remain constant throughout the child's life. Parent's depression waxes and wanes as a chronic illness, so when you're implementing programs perinatal time has got a lot of political

appeal, a lot of constituency behind it, but remember, you want to be thinking much broader time range as well.

There are individual provider and system level barriers that exist to increase the access and quality of care for depressed adults. One of the key issues that we kept coming across is the adult mental health system does not when it looks at the function of an adult, whether you work, whether you're able to do things, it doesn't really look at whether you're able to perform your role as a parent, so it's a key adult life function and yet our mental health system taking care of adults is not looking at their parenting and how their parenting is impacted. So from the first kind of looking at background there was sort of three conclusions the committee wanted to make sure people know, that it's a common condition. It's attributed to multiple risk factors and mechanisms. It may interfere in parenting quality and put children at risk for adverse outcomes and multiple barriers exist that decrease the quality of depression care for adults and particularly for mothers. Mothers were less likely to get into follow up treatment and some of the key things that other adults did.

I'm going to backtrack for a second and just comment on number two again. What we found was that research pointed out that when a parent was depressed both the depression was going on and an impact on parenting and their ability to teach their child appropriate emotional regulation, so when the depression got better the parenting defect was still there and affecting the child, so the conclusion was that we needed interventions, not just to deal with the depression, but that helped enhance parenting

skills at the same time and I think that is a new message, that we need dual treatments here, not just approaching only the depression.

I think later the preventative community is using the same stretch and I think we have an overlapping committee member who probably is responsible. One of the things I guess that is lost in translation is really the focus that we moved all the way up to parenthood and we're really focusing on parent's skill **** and prevention of depression so that we don't get these people to adulthood being unable to parent successfully.

Here is my thing that came through, so here is the time period and we want to intervene in all these places and there is parenting skills and the focus on prevention. Clearly all those are very important. Those are the new items. So in terms of prevention the current evidence is that we want to prevent or improve depression in the parent, but that is a key focus and that we want to target these vulnerabilities of how children learn to handle stress and coping in children of depressed parents. There is exciting new studies that are now coming out showing that we can actually inoculate children and help them successfully make their way through life when a parent is depressed rather than have the next generation legacy for those children. To improve parenting and parent child relationships and use a two generational approach and without bragging about the committee I want to emphasize that this report in separate chapters gives you all the latest research information that you need to know to understand these areas that is so hard to find otherwise.

So screening and treatment interventions for depressed adults are safe and effective, but they're rarely integrated. They rarely consider the parent status or its impact on the child and that emerging preventative interventions have demonstrated promise for improving outcomes for families of children with depressed parents and we need to see how we can bring those into the mainstream. There is still a lot of institutional and social cultural barriers both that cause and sustain disparities and care for depressed adults, so we need to make sure that we're designing culturally sensitive responsive methods of responding to depression in different cultures.

Our vulnerable populations we find that there is really limited research and evaluation of outcomes in these populations, so we would hear about many wonderful community programs with no evaluation, no assessment of costs and outcomes, so when people are doing community programs we're really encouraging people to make sure that you bring your findings and your information into the public arena, so people can use that to justify other programs they'd like to start. Some of the innovative models like Chicago where we had people talk to us as well and we need community based and culturally appropriate care in particular.

This litany of challenges you probably recognize in the Public Health Department because you face it in many conditions, but one of the key issues is that we need two generational approaches and there is starting to be some data that grandparents depression and grandparent's care giving impacts the next generation and we need to have multiple points of access for families and offer patient centered choices to people.

The developmental orientation we have so many versions of families and parents. We need to have not one size, but size that fits everyone. Some of the model programs around the country Ohio, Rhode Island, Illinois are starting to put together unique programs that combine… The Ohio one there is a home visiting program and screens for maternal depression and helps mothers who are at risk for child abuse. The telephone management for families that are on assistance and the Illinois programs that does a comprehensive care model including paying for screening for depression and a consultation service that you'll learn more about.

Speaking of another fine program, many of the families we struggle with, with depression are also affected by other mental issues, a major one being substance abuse. This is an exciting program and **** in Boston that is a substance abuse treatment for Latin American background women and their children and they really deal with a combination of addiction and co occurring disorders, which is a major difficulty to address. All of these programs are happy to share their information.

So the committee's recommendations, we need to improve awareness and understanding of the general public about what is the path that depression leads to difficulties. We have a fairly simplistic public notion out there of happy mothers, happy babies, terrible depression prenatal and then we fix it and life goes on happily and the world is more complex and we need to have more models of supporting… support innovative strategies that are trying to do it differently and improve the collaboration and capacity building. There is a major gap in addressing both in the mental health service

sector and the primary care sector providers having appropriate education and training. If you don't have a workforce prepared to understand you have a major barrier there. We need to improve service coverage and reimbursement strategies. We all talk about this one all the time, but there is some movement happening. We are starting to pay for screening. In a couple states they're extending Medicaid through the whole first year of life for maternal depression treatment because if you have a state that mother's Medicaid stops at six weeks you have a lot of difficulty helping those mothers and there is a lot of descriptive work about depression, but very little work about following the course of women over time and we need more research that actually gives us information about the trajectory of care.

So we have wonderful sponsors and from both the public and private sector and I encourage you to go to the website. Use this resource. It's available entirely online if you don't want to get it otherwise and hope this is helpful. Questions? Just I'm going to be here… have to leave, so if there are just a couple clarifications I can answer them, but we're going to open the end to general questions.

Audience: Does age play a factor in the instance of maternal depression?

ARDIS OLSON: You mean young mothers more. Yeah, young mothers who particularly lack a social support system. You know so young mothers more likely to have more of the hits too of poverty, lack of social support, those kinds of issues, so we get quite high

rates for young teenage mothers, but if they've got the other supports they're not much different. Other questions?

AUDIENCE: What are the states that have been successful in getting the Medicaid benefits extended?

ARDIS OLSON: I think you're one of them, aren't you? Yep, I'll let him talk a little bit more and I think Wisconsin has as well and New Jersey probably, right? I'm not sure if New Jersey has.

LINDA RANDOLPH: Thank you very much. I'm Linda Randolph. I'm a public health pediatrician and I was on the study committee for the report, which is… This is Preventing Mental, Emotional and Behavioral Disorders among Young People: Progress and Possibilities and I also was fortunate. I am one of the community based members of the study committee. I'm the president and CEO of the Developing Family Center in Washington DC. These are our committee members, Dr. Ken Warner, Dr. Thomas Bolt and Maryellen O'Connell was our study director. Our charge for this committee was to review promising areas of research to highlight some areas of key advances and persistent challenges, to examine the research base within a developmental framework and I'll underscore developmental, by the nature of the population that we're talking about, review the current scope of federal efforts and recommend areas for emphasis for future federal policies and programs of research. One of the things that we came to grips with as a committee was trying to center

ourselves in terms of the theme of what we were trying to accomplish and that was basically to say that there is a scientific foundation that has been created in the nation that will create a society in which young people can arrive at adulthood with the skills and the interests and the assets and health habits needed to live healthy, happy and productive lives in caring relationships with others and this was really our central theme and around which we developed our investigation in terms of the research that existed to date and also what the recommendations were.

We know that there is a substantial gap between what is known and what is actually done and this is not new to anybody who is in the field, but the committee felt that we needed to have a national effort to build on extensive research that is available by implementing an evidence based preventive interventions, by testing their effectiveness in communities because once you get out of the randomized controlled trial environment and try to apply it in communities you have variations in terms of what the dosage of the intervention is, some of the other characteristics and you have to test the effectiveness.

Disseminating prevention principles and addressing gaps in the available research and monitoring the progress at the national, state and local level. This was surprising to many of us even on the committee, that about one in five young people have a current disorder and that it's estimated that about 247 billion dollars in annual treatment and productivity costs to the nation. In addition, there are other costs in other systems outside of the mental health system in education, in justice, in healthcare, in social welfare and not the least of which is the cost to individuals and families.

Prevention opportunities early in life: About three quarters of adult disorders had their onset by the age of 24. About half had the onset by the age of 14 and so when we said young people we were really looking at from birth to about 25 years of age and that first symptoms occur two to four years prior to a diagnosable disorder. The other opportunity here, especially early in life is that common risk factors… there are common risk factors for multiple problems and disorders, so here are the core concepts of prevention and we basically said prevention requires a total paradigm shift. That's a Hackney term now, but what it really means is that mental health and physical health are inseparable. That successful intervention is inherently interdisciplinary. That mental, emotional and behavioral disorders are developmental in their nature and their appearance and that coordinated community level systems of care are needed to support young people and that the developmental perspective is key.

You've seen this before. You will see it again. I have two handouts here. On handout is for researchers. One handout is for policymakers and one of them has this slide in it, so you can take it away with you and there is another slide that I'm going to show you in a minute that's in the other document, but I really want to show that this is interventions by developmental phase and the kinds of interventions are interventions that have had significant evidence findings in terms of randomized controlled trials and that is what we attempted to do. In the report, in the full report you'll actually see there are about thirty some different programs that are identified in the report that talks about the kinds of interventions and the scope. This is the other one. What the paradigm shift is, is to

move from the right to the left. That may not be a good metaphor necessarily, but from maintenance and treatment to promotion and prevention and we spent quite a bit of time talking about the difference between promotion and prevention. Promotion is healthy development, promoting healthy development and prevention is looking at risk factors and protective factors and I'd like to stress that because we have a tendency to only look at what we call the deficit model, which is the risk factors. There are protective factors as well and there are different kinds of intervention strategies depending upon the populations that you're looking at, whether you're going to do a universal intervention, whether you're going to pick a certain segment of the population and do a selective intervention or whether you're going to do some individual kinds of interventions for individuals. For example, if you're looking at individuals with schizophrenia you're looking at actually preventing schizophrenia is looking at the prodromal. You know you can identify two to four years before an actual psychotic event takes place that it is likely to occur and there are some interventions that are possible to delay or ameliorate that manifestation.

Public education around the notion of prevention: Evidence based programs taking the evidence from the randomized controlled trials and applying them. Implementing policies that support families and address poverty and support healthy development and then adopting some key principles like eliminating or reducing exposure to what we call toxic events like harsh discipline or abuse and neglect, positive reinforcement in terms of social behavior and creation of nurturing environments and reinforcing positive behaviors.

Program implementation, three general approaches. Implement an existing evidence based program as it actually was developed, which is kind of the strict implementation of it. Adapting an existing program to community needs or looking at community driven implementation from the beginning, but in each of these there needs to be evaluation and ongoing knowledge about development and that's critical and that's the piece that is often missing in terms of implementation, so somebody takes an evidence based intervention, applies it in the community. They don't have any resources available to actually evaluate the effectiveness of it when it is out of the strict research environment.

Recommendation themes are putting knowledge into practice and continuing the course of rigorous research. Make healthy mental, emotional and behavioral development a national priority and establish some public prevention goals. We called on the White House to establish ongoing multi agency strategic planning mechanisms and align federal resources with that strategy and that states and communities should develop network systems. Health and Human Services should provide annual prevalence data and data on key risk factors. A lot of this information is not available on an annual basis.

Braided funding, that means looking across what I call the silos of federal funding and figuring out from a community's perspective how you put those funding streams together in order to have the impact that you want. Fund state and local researcher community network partnerships, target communities with elevated risk and develop

training and certification standards. For continuing a rigorous course of research a research plan should be developed, a ten-year research plan.

Research about implementation, basically what we found is that there is very little research that's done after you've done the initial randomized controlled trial. What does it take to move from that to actual implementation in various communities, in various settings across various groups? Adaptation of the model requires continuous evaluation, feedback, identification of core program elements, testing models at scale. That's one of the things in looking at going from an individual program to a community wide or a statewide initiative. What does it take to do that and also what are the barriers that exist in attempting to do that and basically how do you bring in community driven models that have actually tested out some kinds of prevention interventions, but basically have not had all of the necessary resources in terms of not only evaluation, but also relationships with academic institutions and other entities that are in the business of doing research?

For additional information it's available at this website. The report is available for purchase. You can go on this website and you can get a free summary. The two briefs here are also on the website and you may take copies of that and also we had some audio and presentations from a March event in 2009 where we actually discussed in more detail about dissemination. I think I got through with time, but I think we may not have time for questions. Yeah, we're going to do… Okay, for the rest of us we'll have questions at that end. Thank you again.

TONYA GORHAM: Thank you. Good evening… afternoon. I'm Tonya Gorham. I am the director of policy with an organization called the LA Best Babies Network and my presentation is on building partnerships to eliminate policy barriers to screening for maternal depression and so my presentation is a little bit different. It's talking about our local effort and our partnership with the LA County Perinatal Mental Health Taskforce and how we went about identifying some of the policy barriers and developing some recommendations for solutions to eliminating those barriers.

Just as you know maternal depression is a widespread public health issue, yet 50% of women with perinatal depression are never treated. This is just a look at some of the surveys in Los Angeles County. In terms of self reported depression during pregnancy for one of our local surveys it showed the 34% of the women have reported depression and self reported postpartum depression 20% reported depression.

The Los Angeles County Perinatal Mental Health Taskforce was formed in February 2007 and it was really formed in response to Governor Schwarzenegger's veto of legislation on perinatal depression that would have required screening. Well it wouldn't have required screening. It would have required that doctors provide women with information on depression and potential resources. He vetoed that message and in his veto message he said that the state should be coordinating with local Department of Health Services and local county departments to make sure that the information is getting out there to women and make sure these efforts are going on anyway is what he

said and so the taskforce developed. It was developed by a woman my the name of Kimberly Wang who is a survivor of severe perinatal depression with her daughter who is now six years-old and she was a volunteer with an organization Postpartum Support International and so she works as a legislative advisor for the Public Defender's Office and so this is kind of her normal work, but she was passionate about this particular issue. Some of our partners include the LA County Public Health Maternal Child and Adolescent Health Programs, Department of Mental Health and a couple of the universities are also involved and LAUSD is at the table as well.

The taskforce has been effective in influencing screening practices and health systems and public health programs. We've increased trainings for providers on perinatal depression and we've also jointly with my organization, the LA Best Babies Network planned a five-year policy initiative to address the issue. The policy initiative is a five year long project from July of 2008 until 2013 and it was funded by First Five Los Angeles, which is a commission in Los Angeles that was started by tobacco tax funding in California and part of the goal of the project is to improve access to the perinatal mental health services in supporting universal screen and referral for women and also to increase awareness among policymakers of perinatal depression and identify the appropriate policy changes needed to increase education and training for providers and improve access to women. Some of our short term goals were to identify key recommendations and develop a strategy and action plan and advocacy plan around the issue and to identify a legislative champion. I'm going to through some of these a little bit quicker. And some of our long term goals are to gain support of our LA County

Board of Supervisors around having coordinated perinatal mental health services for women and then also to have a hearing on depression, a statewide hearing and then also eventually legislative language, hopefully regulatory language supporting universal screening.

The first step was to do community outreach, which we did and we brought on some key partners, which I'll talk about later, but the second phase was develop a landscape report on maternal depression and we looked at what was already being done in LA County in terms of screening and treatment services and what you know what… where were the gaps in Los Angeles County and so we had that report. I had them with me actually if anyone wants copies. I didn't bring very many copies, but I'd be happy to share that report with you all.

The third phase was to hold a policy roundtable which we held in November of 2009 where we brought together perinatal health professionals, mental health professionals, policymakers were all at the table, university, academics were at the table as well to discuss the issue and begin to develop our policy recommendations and agenda.

Some of the successes so far in our project, the taskforce, we incorporated key members like I said. One of our key members, the Junior League of California they were very active in sponsoring a piece of legislation last year, AB159, which would have carried a statewide taskforce that would have been modeled after our LA taskforce. That bill was stalled unfortunately in our state legislature, but we've moved forward and

I'll share some of that with you later, but we've moved forward with that as well. And then also the taskforce increased local support for our legislation and we testified on it and did some different activities around it as well. We also co hosted with Postpartum Support International their annual conference on perinatal depression in Los Angeles and we received a proclamation from our board of supervisors in August of 2009 during that conference declaring August Perinatal Mood Disorder Awareness Month.

So again, the policy roundtable was held November 19th and during the policy roundtables we broke up into groups. We had keynote speakers. We broke up into groups and the people really at the table discussed issues related to these four topic areas, access and financing and standards of care, which is a big one, education and training for healthcare providers, mental health workforce issues and public awareness education and social support. Under the access and financing some of the recommendations that came up and which have already been mentioned are to extend Medical coverage beyond the 60 days postpartum for those women who have pregnancy only Medical in our state, sorry, Medicaid. Expand Medical fee for service insurance coverage for Dyadic mental health screening to reimburse pediatricians who screen for maternal depression was one of the key recommendations that came up as well.

Under the standards of care that particular group really looked at you know adopting best practice models approaching screening so that screening is done throughout every trimester and then treatment services that were inclusive of a lot of different types of

treatments and types of models of treatment. The education and training of healthcare providers group they recommend and we are actually actively doing this now, developing a perinatal depression toolkit for healthcare providers and then so obviously trying to get support to get that toolkit disseminated to perinatal providers, but then also to train them on it as well and then also to support research on the physiological changes that occur during pregnancy that may cause perinatal depression and to also disseminate this information through our speaker's bureau, so we're actively now developing our speaker's bureau. We have quite a few experts in Los Angeles at the table already who are signed up to participate in that speaker's bureau.

The community awareness and social support group they said support community based organization programs and informational educational centers for… as informational and educational centers for women, families and communities members. Programs should utilize community driven approach and utilize community members as health navigators and then also support a public awareness campaign that educates women, families and communities on perinatal depression and that's also another recommendation that we've been active in implementing. We are in the process of developing a campaign in May to kickoff in May of this year which will be a community awareness campaign in Los Angeles County.

And the mental health workforce group they recommended expanding linkages, raise visibility and increase access to the mental health workforce that already exists. So they felt like there were already some experts out there, some people who are already

treating women with perinatal depression and so that we needed to be able to connect the OBs or the other health providers to those mental health services that were already out there and then also support specialized training for mental health workforce and then to do like a train the trainer model where you're training people on being able to you know support, provide some type of support for women with perinatal depression.

Some of our current activities, I've already talked a little bit about our community awareness campaign, but on a larger scale… That's an LA County community awareness campaign, but on a larger scale the bill that I mentioned earlier AB159 has kind of shifted. Like I said it got stalled because of budget issues in our state, but it shifted into a resolution, so it's now a semi concurrent resolution 105, which would proclaim every May of every year perinatal depression awareness month for California and so we're moving with the author's office now on pushing that, moving that forward and we're also in the process of planning a legislative hearing in May to begin the awareness campaign through the women's caucus of our state legislature and the assembly health committee of our state legislature as well. And so we've been working kind of behind the scenes with our LA County leaders, our LA County Board of Supervisors to you know support this resolution on a state level, but then also to take a leadership role in doing the community awareness campaign in LA as well. We are like I said developing a toolkit for providers, developing a speaker's bureau and developing training programs for staff at county departments. Our taskforce is actually in the process of training different county departments on perinatal depression and it may be some of those nontraditional departments that… who come in contact with women, so

the first department that we worked with is the Public Defender's Office, which is where our chairperson works, but with the attorneys in the Public Defender's Office who deal with you know these… deal with women suffering from depression on a daily basis and to make them more aware of it and how that impacts every aspect of their lives and so they received that training… will receive that training. I'm sorry, on May 17th and then from there we'll be doing a training with hopefully with the Department of Children and Family Services as well and then we are also in the process of planning a pilot program. We've received funding through the Atlas Foundation for our taskforce, to support our taskforce, but they've also kind of opened the door to other funders who have agreed to support a pilot program that we're in the process of implementing in which we'll place mental health providers at a very unique kind of community center that has been developed in the particular area in Los Angeles called Magnolia Place and so we'll be kicking that off hopefully in the next fiscal year, so July, August of this year we'll be able to kickoff that pilot program as well.

And just for more information this is our website, LA Best Babies Network and then the task force website is LAPerinatalMentalHealth.org and I have kind of a one-pager on the taskforce, but I also have a one-pager on the recommendations and I know I just kind of ran through those, so if you want information on some of the policy recommendations I'll be happy to share those with you. Thank you.

VAMSI VASIREDDY: Hello everyone. I thank you for staying through the end. I know it's the end of the day and my name is Vamsi Vasireddy. I'm a public health physician, a

Cal Systems consultant by day. Don't ask what I do by night. I had to regain my sanity somehow from working in the day as a public health physician, so I do restaurant critiques and write about travel, nothing scandalous. We're talking about how we developed perinatal mental health systems to **** perinatal mental health disorders in the state of Illinois. This is a picture that we show before we start our presentations. It's a picture of a mother holding her baby and guarding against the demon that you see in the form of a bat flying in the corner. It's a challenge for mother every day, especially when they have mental health issues to protect themselves and their children from the demon that we call depression or mental health disorders during pregnancy and postpartum.

Just to give you an idea of the magnitude of problems in the state of Illinois, the research shows that about 9.4 to 12.7% of pregnant women have a major depressive episode. About 21.9% develop postpartum depression. That's according to some published articles and in 2001 which we… Our project has been in place since 2005, so this is what… The data we use is from 2001. Only 607 of the 81,000 women with Medicaid funded **** in Illinois were diagnosed with depression. As you can see that is only .75%. If we go by the published research that 9.4 to 12.7% have a major depressive episode that is quite negligible, the amount of women that are being diagnosed.

So a taskforce was formed in Illinois back in 2004, 2003, 2004 after there were a series of high profile deaths. There was the one resident who actually committed suicide from

being depressed while she was pregnant. She jumped from on top of a building. Her parents were sort of well known figures in the Chicago social scene, so her mother started initializing a taskforce with all the mental and child health professionals in the state and city to address the issue of postpartum depression on perinatal depression. The questions were how can we improve the detection of perinatal mental health disorders statewide and how can we improve the delivery and quality of the treatment for perinatal mental health disorders. The taskforce found out that the mental health system lacked the capacity to treat most women with mental health disorders. This is the case in many states and not just Illinois. Most perinatal mental health providers lack the knowledge and skills to diagnose and treat perinatal mental health disorders and there is no reimbursement for screening, so basically there is no initiative for providers to screen.

The strategy was to… The central focus was to improve primary care provider capacity to detect, diagnose and screen and treat for perinatal mental health disorders and promote awareness in tandem with the screening and increased provider capacity. So in order to do this our strategy, we decided to do… to tackle it on two levels, provider support and systemic support. By provider support what we do is we just train providers. We provide them tools for screening depression, assessment and treatment and we offer them free consultation strictly for providers, not for patients on various issues related to perinatal mental health disorders. The consultation takes place in the form of onsite, by telephone or through internet. The providers can call us. There is a toll free number and the consultation service is free. We do not provide specific responses to if

the provider say calls and say I have a patient X who is has come into my office with condition Y. We do not answer such questions. We request that because of legal issues we instead ask them to frame the question in a more general way. I have a if say for example there is a case where people… where a woman has a condition Y how, what are the available options for treatment, such kind of issues, but we do offer free consultation. The onsite consultation is… I will have a handout detailing what kind of services we provide for detail.

The systemic support, we finally after the advocacy took off the reimbursement that was provided for screening Medicaid now reimburses in Illinois. There is a single code that to make the life of the providers easier there is a single code that they'll fill in the reimbursement form for depression screening, so there is reimbursement for screening for Medicaid patients.

We do have models for integrated care that have been researched and published and we provide tools for self care, which are currently being tested in a couple of clinics in the Chicago area and we developed a statewide network for perinatal mental health providers because you can't just train providers and leave them like that. You have to create a network where people can easily access, gets to the point of access of care.

The different types of trainings we provide are the basic workshop where a physician or a nurse practitioner or any mental healthcare provider comes to us and says we have basically a clean slate. "We don't know what to with mental health." "We have mental

health patients, but we don’t know what to do.” That’s where we start with a basic workshop and then go onto the advanced skills workshop depending on the audience screening and assessment, psychopharmacology. If they are more of an advanced set of physicians that’s what we offer and assessment. We also offer mother and **** relationship trainings for social workers and early intervention specialists.

Since workshops are not just enough, you can’t just… Like I mentioned we can’t just train providers and leave them to go do you thing. You can’t just say that. You have to provide them support for later on. That’s why we offer the perinatal mental health consultation service. It’s a resource for providers to consult with our experts on perinatal and mental health, accessed by toll free line. You can also access our service through the website where you go in and fill in your question. If it’s not… Our turnaround time is 24 hours. We do not call it a hotline because it is not. It’s a warm line since it’s not a hotline. We do respond within 24 business hours, within a day. The service is free of charge. We get calls even from other countries, not just other states. Consultants are multidisciplinary faculty and staff from ****. We have a team of psychiatrists, social workers, nurse practitioners and public health professionals on the team.

We also developed models for perinatal mental health where the screen and refer model, which are models for care that we train providers depending on the capacity of their clinic, depending on what kind of services they are looking to provide we go and train them on different models. One of them is a screen and refer model where they screen the patients onsite and refer them to a mental health professional outside their

clinic. This usually works in community health centers where they may or may not have a mental health professional onsite, so they screen onsite and then send the positive screens to you know for example our hospital.

The screen, assess and refer model where they also… besides screening and referral they also provide assessment onsite. If they have a little more advanced staff this is what we train them on doing. The stepped care model is the one that we have been implementing in two community… Actually FQHCs, federally qualified healthcare centers, screen all patients. It's based on stepped care as the name suggests. What you do step by step if a positive screen comes in and a positive assessment or how do you treat the patients, one after the other steps. It's is provided to retain the patient base within the clinic because when you're… what research shows is that when you refer patients outside your clinic many of them do not follow, so we don't want to miss those women who will not follow up on their referrals, so this is what we train providers on how to treat onsite and if the only case which we have suggested that they refer to a mental health advance professional is when there are cases of bipolar disorder, usually that is one of the more complicated situations.

This is our stepped care model. As you can see it starts with screening. We use the patient health questionnaire ****. If the **** less than****, 5 to 19, depending on the score how do you go, the right boxes are where you take action. There is no intervention assessment mental health referral and then again medication offered, explain, if the patient accepts your screen back, screen them again at four week, after

the four week visit and then the eight weeks and then the maintenance treatment. If anybody is interested I can email or provide you this slide, but this is the stepped care model we train the providers on.

One of the advantages to **** stigma because most of the times when you refer them the mother to an outside or another they are not ****. They are not likely to follow. It raises the logistical barriers, transportation, time and expense. It's continuity of care, which is the most important thing in mental health. You do not want to miss these patients. It's cost effective. It is general depression… They have been shown to improve the quality of care, the depression stepped care models. This **** introduced **** Medical Center, which is a FQHC, mostly Spanish speaking, actually 97% of this population is monolingual **** Spanish speaking, below 200% poverty level. Our screening average after introducing the model has gone up to… Prior to the model there was only .4% of women diagnosed, but the screening has gone up to 58% and we do constantly monitor the quality of screening in these clinics by providing them technical assistance.

I don't know if we have time to… Okay, we'll skip the FDA categories because… One of the other consultation services we provide is a free medication chart specifically for prescribers where we are funded by HRSA to compile the latest research in perinatal mental health. Any research that is published we take into consideration because the drugs are constantly being upgraded or downgraded and the PDR, the reason I provide a picture of PDR is because PDR does not update itself often. It is highly unreliable

when it comes to mental health drugs, especially pregnant women. So the categories don't mean a thing after awhile, so we have a medication chart that we provide, which basically outlines the pros and cons, the neonatal side effects, **** and all the citations for research and the dosage for lactating mothers, basically all information about most of the mental health drugs so the physician can.. or the prescriber, whoever it is can make an informed decision as to what to prescribe, what not to prescribe. It's also free of charge. It's available actually on our website for a free download if anybody wants to go ahead and download it.

Healthcare and Family Services, which is Illinois State provides the reimbursement for depression screening now. We also manage tools for all the providers that attend our workshops. We mail them provider notices. We provide them… We constantly remind them to access our website for updates on drugs and any latest research. We also offer provider training sessions, which used to be free when HRSA funding was available, but now it's not. We still offer them, but for a nominal charge.

There is onsite consultation for improving the systems, the depression screening systems that we provide. We go to the clinics and help them implement the stepped care model or the screen and refer model, whatever model fits their clinic. Medicaid managed care organizations it's a… Illinois has a system where they use the perinatal depression screening as a quality indicator for MCOs and the charts that **** for depression screening and that's one of the ways the state keeps track of the MCOs if they are providing screening services or not.

We have very good legislative support. The Perinatal Mental Health Disorders Prevention and Treatment Act that was passed, it provides… It states that all licensed mental healthcare providers… perinatal care providers should educate women about mental health disorders **** opinions. Hospitals will inform and the Department of Health and Human Services will supply alternative information that can be used for this purpose. They provide provisions for screening and assessment and after we have achieved our legislator support we decided that just because we also need to collaborate with nonprofits and other agencies in the state that provide similar services and since we are only providing our service for providers we also need to have a consumer piece. This is where the collaborations come in where there are other organizations that provide… The EDOPC is one of the organizations that provides trainings for and wellness for consumers. The **** system has a referral system exclusively for patients where they can call a toll free number, 866-ENHMOMS where the patients can call in and say I'm in so and so location, who is the nearest perinatal mental healthcare provide who is qualified to treat my condition and they provide information for the various providers.

These are other key collaborators in the field, which have been helping us to spread our work. We have collaboration meetings annual and ****. Our funders, HRSA, Michael **** Health Trust and **** Healthcare and Family Services. HRSA funding ran out in September, but still cite them. This is our toll free consultation number if anybody, any of you are providers and need further information about drugs or screening models,

assessment models. One other thing is we are probably the only people who are authorized to distribute all the depression screening tools in 16 different languages, so if you have people, patients who are of **** different language and we are constantly adding other languages to the list. We currently have 16 so far. We use the Edinburgh depression screening tool. So if anybody needs those we also provide it free of charge. Our project website, the US and Mental Health Project website and that's our program director.

Finishing, that's a statue in our building outside our psychiatric department. It's a mother holding her baby on top and fighting a demon on the near her feet to prevent the demon from attacking her baby. Thank you. If you have any questions I have a handout where you can get further information about us. Yes, please.

Audience: Just a couple of you have mentioned reimbursement for perinatal screening, but how pediatricians who screen moms? Do they get reimbursed?

VAMSI VASIREDDY: Yes.

AUDIENCE: And through the child's insurance or through the mother's, which we don't have access to.

VAMSI VASIREDDY: That's a good question. I do know that pediatricians come under as primary healthcare providers in Illinois, so they get reimbursed. Medicaid I don't

exactly know, but I can find out for you if it comes out from the mother's or the child's insurance.

AUDIENCE: Because that would be helpful.

VAMSI VASIREDDY: But one of the target groups for us is actually pediatricians because the mother is more likely to see a pediatrician before she even goes to a primary. Yes.

AUDIENCE: Right, **** the whole business of well it's not the mom. I mean it's not the child.

VAMSI VASIREDDY: Yes, any others?

AUDIENCE: I'm from Ohio and we are currently using the PH29 in our **** clinic along with having a ****, so I guess I'm a little confused. I came in late. Who are you training to provide the mental health services to a mother that is for…? Because you talk about the ****, correct?

VAMSI VASIREDDY: Yes.

AUDIENCE: So if they score better than a five who are you training to go into do an intervention? I think I must have missed that.

VAMSI VASIREDDY: The audience for our training specifically for your question is the provider who is usually the primary healthcare provider, the physician, basically the most likely or the OB or a family practitioner who does the… or a nurse practitioner too sometimes because in some clinics the… We have had some issues with OBs who did not want to provide mental healthcare service who were referring patients to a mental healthcare professional onsite. Some clinics have that luxury of referring onsite, so in that case when we go to do the trainings we encourage everybody who is a provider to come to the training, so if one person does not want to treat the patient the other person is at least trained enough to treat the patient. It's usually the physician. But the screenings are administered by the medical assistants or nurses or depending on whoever the clinic assigns. Yes, the screening is administered by them and scored even by the medical assistant, but the assessment is conducted by either a nurse practitioner or a physician.

AUDIENCE: So but there is no… Because I'm just like **** confused about the treatment because **** license for I don't know **** a license to do a social worker or a counselor to even provide the treatment, so I guess I was just…

VAMSI VASIREDDY: Yes, yes, the treatment part, the assessment and treatment part goes to the physician, nurse practitioner or social worker, but the administering the screening and scoring the screening tools mostly is usually done by some social worker or a medical assistant onsite, depending on whoever the clinic can assign it to.

AUDIENCE: I think that to charge for it, it can be done by anybody, but it has to be interpreted by physician or a ****.

VAMSI VASIREDDY: Yes, yeah, absolutely.

AUDIENCE: Can you repeat your last name?

VAMSI VASIREDDY: Sure, I will show you. I also have a handout if you want to take with all the information. For consultation questions that's our main web, the project website and the main website is the UIC website and that's our toll free number that you can call.

LIBRADA ESTRADA: Do you have any questions for Linda or Tonya?

LINDA RANDOLPH: I might just make a comment and that is that a lot of the discussion has… A lot of the discussion has been around screening for particular conditions. The prevention report is actually talking about a different paradigm. It's talking about screening for risk factors, not for a condition per se and when you look at the risk factors you take a totally different approach and a more comprehensive approach and a more developmental approach for what is happening for a child and a family and it's something that we in the committee talked a lot about and had to be able to articulate that you weren't saying necessarily that it there was a cause and effect, but that you

know that these are risk factors and they are cumulative and interlocking risk factors and the more risk factors that you have the more likely is that you're going to have some manifestation of a problem and so that's sort of a different perspective relative to screening. There is a whole chapter in this book on the whole issue of screening when you're looking at it from a prevention, a broader prevention context.

LIBRADA ESTRADA: Thank you.

Audience: My question sort of deals with that because with my early Head start hat on I can hear in your screening for risk and your broad perspective how early Head Start might benefit from some of the training, some of the interaction. I really couldn't hear any inclusion of early Head Start in the other two presentations or where they might fit in that early Head Start programs utilize **** professionals, nurses, social workers to work for ameliorating some of the social and environmental conditions for mothers and infants and as well as pregnant women.

TONYA GORHAM: I would say in terms of our recommendations are to reach programs just like that early Head Start and to work with other programs like that where women are meant to be able to you know assess you know provide that training, provide that information to those organizations so that they are able to be able to identify the risk, be able to identify you know some of the screening… use the screening tools and so part of our recommendation is just that, to be able to work with those groups. One of our projects that we've just implemented is called Welcome Baby and it's working with

women who are starting off pregnant and so they… and then they receive home visits after the baby is born and just identify, you know following women throughout from like three months before they deliver until about a year after they deliver and being able to assess in different environments including the home environment, so you know we are reaching out to all programs.

VAMSI VASIREDDY: One of the things that we're doing in Illinois is the state sends out reminders for the MCOs Medicaid, Medicare management organizations who also deal with the Head Start programs in… to schedule training sessions for their providers, so we have conducted training sessions for people from Head Start before. We don't directly reach them, but they are reached… connected to us through the managed care organizations.

LIBRADA ESTRADA: Other questions or comments? No, okay. Well I'd like to thank our speakers for a very good presentation.

VAMSI VASIREDDY: And please our consultation service is free for not just Illinois, but all across the country, so if you have any questions feel free to call.